AMENDED IN ASSEMBLY APRIL 20, 2005

CALIFORNIA LEGISLATURE—2005–06 REGULAR SESSION

ASSEMBLY BILL No. 1111

Introduced by Assembly Member Frommer

February 22, 2005

~~An act to add Article 3.12 (commencing with Section 1357.40) to Chapter 2.2 of Division 2 of the Health and Safety Code, relating to~~ *An act to amend Sections 1373.62 and 1399.801 of, and to add Article 3.12 (commencing with Section 1357.40) to Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10127.15 and 10900 of, and to add Section 10901.5 to, the Insurance Code, relating to* health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1111, as amended, Frommer. Individual health coverage~~ market reform.~~.

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the provisions governing plans a crime. Existing law also provides for the licensure and regulation of health insurers by the Department of Insurance.

Existing law prohibits a health care service plan or health insurer providing coverage under an individual plan contract or individual insurer benefit plan from declining to offer coverage to, or denying enrollment of, a federally eligible defined individual with specified prior creditable coverage, or imposing any preexisting condition exclusion with respect to the coverage. Existing law requires health care service plans and health insurers to offer continuation health benefit coverage under its standard benefit plan to specified individuals who are without that coverage.

The bill would include as prior creditable coverage past coverage issued to a person as a federally eligible defined individual. The bill would prohibit a health care service plan or health insurer from rejecting an application for continuation coverage under its standard benefit plan from an individual who has been enrolled in a standard benefit plan for at least 12 months and wishes to enroll in a different standard benefit plan.

This bill would require that health care service plans and health insurers fairly and affirmatively offer, market, and sell all contracts to individuals in each of the plan's service area. The bill would prohibit a plan or insurer from rejecting an application where an individual agrees to make the required premium payments and the individual and their covered dependants work or reside in the applicable service area. The bill would prohibit establishing rules for eligibility under these provisions based on specified health status-related factors.

Because a willful violation of the provisions related to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law provides for the licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions by a health care service plan is a crime.~~

~~This bill would enact various market reforms relative to individual health care coverage. The bill would impose requirements on age categories and geographic region service areas used by plans. The bill would require plans to fairly and affirmatively market and sell all plan contracts available in each service area. The bill would impose limitations on late enrollee and preexisting condition exclusions. The bill would require contracts offered to individuals under these provisions to be renewable except under particular circumstances. The bill would impose limitations on plan contract premiums. The bill would impose certain requirements on solicitors selling plan contracts and relative to the marketing materials used for individual plan contracts. The bill would authorize the Director of Managed Health~~

~~Care to adopt regulations to implement these provisions. The bill would enact other related provisions.~~

~~Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Article 3.12 (commencing with Section 1357.40) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:

Article 3.12. Individual Health Coverage Market Reform

1357.40. (a) This section shall apply to coverage for individuals who have maintained continuous coverage in the individual market for at least two consecutive years and who apply for coverage within 63 days of any termination of coverage when that termination is not based on fraud or nonpayment of premiums. Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each individual all individual health care service plan contracts that the plan offers and sells to individuals in this state.

(b) The plan may not reject an application from an individual for a health care service plan contract if the individual agrees to make the required premium payments and the individuals and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.

(c) No policy or contract that covers an individual may establish rules for eligibility, including continued eligibility, of any individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

SEC. 2. Section 1373.62 of the Health and Safety Code is amended to read:

1373.62. (a) (1) This section shall apply only to a health care service plan offering hospital, medical, or surgical benefits in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, or a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations shall not be subject to the requirements of this section.

(b) For the purposes of this section, "program" means the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code).

(c) (1) Each health care service plan subject to this section shall offer a standard benefit plan. The calendar year limit on benefits under the plan shall be at least two hundred thousand dollars ($200,000), and the lifetime maximum benefit under the

plan shall be at least seven hundred fifty thousand dollars ($750,000). No health care service plan is required to provide calendar year benefits or a lifetime maximum benefit under the plan that exceed these limits. In calculating the calendar year and lifetime maximum benefits for any person receiving coverage through a standard benefit plan, the health care service plan shall not include any health care benefits or services that person received while enrolled in the program.

(2) The standard benefit plan of a health care service plan participating in the program shall be the same benefit design it offers through the program, except for the annual limit required under paragraph (1). If the health care service plan offers more than one benefit design in the program, it shall offer only one of those benefit designs as its standard benefit plan.

(3) (A) The standard benefit plan of a health care service plan that is not a participating health plan within the program shall be any one benefit design that is offered through the program by a health care service plan participating in the program, except for the annual limit required under paragraph (1).

(B) A health care service plan that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health insurer that is also an insurer in the individual market may satisfy the requirements of this section and Section 10127.15 of the Insurance Code if either the plan or insurer offers a standard benefit plan.

(C) A health care service plan that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health insurer that is in the individual market and that is a participating health plan in the program is exempt from the provisions of this section if the insurer meets the requirements of Section 10127.15 of the Insurance Code in offering a standard benefit plan.

(d) (1) A health care service plan may not reject an application for coverage under its standard benefit plan for an individual who meets any of the following criteria:

(A) Applies for coverage within 63 days of the termination date of his or her previous coverage under the program if the

individual has had continuous coverage under the program for a period of 36 consecutive months.

(B) Has been enrolled in a standard benefit plan, moves to an area within the state that is not in the service area of the health care service plan or health insurer he or she has chosen, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(C) Has been enrolled in standard benefit plan that is no longer available where he or she resides, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(D) Has been enrolled in a standard benefit plan for at least twelve months and wishes to enroll in a different standard benefit plan.

(2) Notwithstanding any other provision of this section, a health care service plan is not required by this section to accept an application for coverage under its standard benefit plan for any individual who is eligible for Part A and Part B of Medicare at the time of application and who is not on Medicare solely because of end-stage renal disease.

(e) The amount paid by an individual for the standard benefit plan shall be 110 percent of the contribution the individual would pay in the program for the benefit design providing the same coverage, using the same methodology in effect on July 1, 2002, for calculating the rates in the program. If a health care service plan offers calendar year and lifetime maximum benefits in its standard benefit plan that exceed those in the benefit design offered through the program, it may not increase the amount paid by the individual for the standard benefit plan. The limitation on the amount paid by an individual pursuant to this section for a standard benefit plan shall not apply to any individual who is eligible for Part A and Part B of Medicare and who is not on Medicare solely because of end-stage renal disease.

(f) (1) Prior to offering a health benefit plan contract pursuant to this section, every health care service plan shall file a notice of material modification pursuant to Section 1352. Prior to renewing the contract, the plan shall file an amendment or a notice of material modification, as appropriate, pursuant to Section 1352.

(2) Prior to making any changes in the premium charged for its standard benefit plan, the health care service plan shall file an amendment in accordance with the provisions of Section 1352 and shall include a statement certifying the plan is in compliance with subdivision (e).

(3) All other changes to a plan contract that was previously filed with the director shall be filed as an amendment in accordance with the provisions of Section 1352, unless the change otherwise would require the filing of a material modification.

(g) (1) Each health care service plan shall report to the Managed Risk Medical Insurance Board the amount it has expended for health care services for individuals covered under a standard benefit plan under this section and the total amount of individual payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) September 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to August 30, 2007, inclusive.

(2) "Health care services" means the aggregate health care expenses paid by the health care service plan or insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health care service plan. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate such expenses for participating health plans in the program. The "standard monthly administrative fee" is the average monthly, per person administrative fee paid by the program to participating health plans during the reporting period.

(3) The "total amount of individual payments" is the aggregate of the monthly individual payments charged by the health care service plan during the reporting period. The calculation of the total amount of individual payments charged shall be consistent with the methodology used on July 1, 2002, to

calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of the individual payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health care service plan and the individual payments received by the plan. The verification shall include assurance that the individual was enrolled in the standard benefit plan during the reporting period in which the health care service plan paid health care expenses on the individual's behalf, and that the expenses reported are consistent with the standard benefit plan.

(h) (1) The program shall pay each health care service plan an amount that is equal to one-half of the difference between the total aggregate amount the health care service plan expended for health care services for individuals covered under a standard benefit plan who have had 36 consecutive months of coverage under the program and the total aggregate amount of individual payments charged to those individuals who have had continuous coverage under the program for a period of 36 consecutive months. For purposes of determining the amount the program shall pay each health care service plan, the total aggregate amount the health care service plan expended and the total aggregate amount of individual payments shall not include amounts paid by or on behalf of an individual who is eligible for Medicare Part A and Medicare Part B and who is not on Medicare solely because of end-stage renal disease. The program shall make this payment from the Major Risk Medical Insurance Fund or from any funds appropriated in the annual Budget Act or by another statute to the program for the purposes of this section. The state shall not be liable for any amount in excess of the moneys in the Major Risk Medical Insurance Fund or other funds that were appropriated for the purposes of this section. If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health care service plan, the health care service plan may increase the monthly payments that individuals are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

(2) The Managed Risk Medical Insurance Board shall make a biannual interim payment to each health care service plan providing coverage pursuant to this section. For the first two reporting periods described in this section, biannual interim payments shall be calculated for each individual as the product of the average premium in the program for the period of time the individual was enrolled during that reporting period and one-half of the difference between the program's prior calendar year loss ratio and 110 percent. For subsequent reporting periods, the Managed Risk Medical Insurance Board may, by regulation, adopt for each health care service plan a specific method for calculating biannual interim payments based on the plan's actual experience in providing the benefits described in this section. Each health care service plan shall submit a six-month interim report of monthly individual enrollment in its standard benefit plan. The Managed Risk Medical Insurance Board shall make an interim payment to each health care service plan pursuant to this section no later than 45 days after the receipt of the plan's enrollment reports. Final payment by the board or refund from the health care service plan shall be made upon the completion of verification activities conducted pursuant to this section.

(i) The provisions of this section constitute a pilot program that shall terminate on September 1, 2007.

(j) This section shall become operative on September 1, 2003, and shall become inoperative on September 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the dates on which this section becomes inoperative and is repealed.

SEC. 3. Section 1399.801 of the Health and Safety Code is amended to read:

1399.801. As used in this article:

(a) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include

accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under 22 U.S.C.A. 2504(e) of the Peace Corps Act.

(b) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health care plan contract covering the eligible person.

(c) "Federally eligible defined individual" means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18 or more months of creditable coverage, and whose most recent prior creditable coverage was *coverage issued pursuant to Section 1399.804 or pursuant to Section 10901.2 of the Insurance Code, or coverage* under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act

of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and has no other health insurance coverage, (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted this coverage.

(d) "In force business" means an existing health benefit plan contract issued by the plan to a federally eligible defined individual.

(e) "New business" means a health care service plan contract issued to an eligible individual that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, as to a condition for which medical advice, diagnosis, and care of treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

SEC. 4. Section 10127.15 of the Insurance Code, as added by Section 10 of Chapter 794 of the Statutes of 2002, is amended to read:

10127.15. (a) (1) This section shall apply only to a health insurer offering hospital, medical, or surgical benefits in the individual market in California and shall not apply to accident-only, specified disease, long-term care, CHAMPUS supplement, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies or a health insurance conversion policy issued pursuant to Part 6.1 (commencing with Section 12670) of the Insurance Code.

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations shall not be subject to the requirements of this section.

(b) For the purposes of this section, "program" means the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)).

(c) (1) Each health insurer subject to this section shall offer a standard benefit plan. The calendar year limit on benefits under the plan shall be at least two hundred thousand dollars ($200,000), and the lifetime maximum benefit under the plan shall be at least seven hundred fifty thousand dollars ($750,000). No health insurer is required to provide calendar year benefits or a lifetime maximum benefit under the plan that exceed these limits. In calculating the calendar year and lifetime maximum benefits for any person receiving coverage through a standard benefit plan, the health insurer shall not include any health care benefits or services that person received while enrolled in the program.

(2) The standard benefit plan of a health insurer participating in the program shall be the same benefit design it offers through the program, except for the annual limit required under paragraph (1). If the health insurer offers more than one benefit design in the program, it shall offer only one of those benefit designs as its standard benefit plan.

(3) (A) The standard benefit plan of a health insurer that is not a participating health plan within the program shall be any one benefit design that is offered through the program by a health care service plan participating in the program except for the annual limit required under paragraph (1).

(B) A health insurer that is not a participating health plan within the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with, a health care service plan that is in the individual market, may satisfy the requirements of this section and Section 1373.62 of the Health and Safety Code if either the plan or insurer offers a standard benefit plan.

(C) A health insurer that is not a participating health plan in the program that is under common ownership with, is affiliated with, or files consolidated income tax returns with a health care service plan that is in the individual market and that is a participating health plan in the program is exempt from the provisions of this section if the plan meets the requirements of Section 1373.62 of the Health and Safety Code in offering a standard benefit plan.

(d) (1) A health insurer may not reject an application for coverage under its standard benefit plan for an individual who meets any of the following criteria:

(A) Applies for coverage within 63 days of the termination date of his or her previous coverage under the program if the individual has had continuous coverage under the program for a period of 36 consecutive months.

(B) Has been enrolled in a standard benefit plan, moves to an area within the state that is not in the service area of the health care service plan or health insurer he or she has chosen, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(C) Has been enrolled in standard benefit plan that is no longer available where he or she resides, and applies for coverage within 63 days of the termination date of his or her previous coverage.

(D) Has been enrolled in a standard benefit plan for at least twelve months and wishes to enroll in a different standard benefit plan.

(2) Notwithstanding any other provision of this section, a health insurer is not required by this section to accept an application for coverage under its standard benefit plan for any individual who is eligible for Part A and Part B of Medicare at the time of application and who is not on Medicare.

(e) The amount paid by an insured for the standard benefit plan shall be 110 percent of the contribution the insured would pay in the program for the benefit design providing the same coverage, using the same methodology in effect on July 1, 2002, for calculating the rates in the program. If a health insurer offers calendar year and lifetime maximum benefits in its standard benefit plan that exceed those in the benefit design offered through the program, it may not increase the amount paid by the insured for the standard benefit plan. The limitation on the amount paid by an individual pursuant to this section for a standard benefit plan shall not apply to any individual who is eligible for Part A and Part B of Medicare and who is not on Medicare solely because of end-stage renal disease.

(f) (1) Prior to offering a health insurance policy pursuant to this section, every insurer shall file a notice of any changes pursuant to Section 10290 and to Section 2202 of Title 10 of the California Code of Regulations. Prior to renewing a policy, the

insurer shall file an amendment or notice of any changes, as appropriate, pursuant to Section 10290 and to Section 2202 of Title 10 of the California Code of Regulations.

(2) Prior to making any changes in the premium charged for its standard benefit policy, the insurer shall file an amendment in accordance with the provisions of Section 10290 and of Section 2202 of Title 10 of the California Code of Regulations.

(3) All other changes to an insurance policy that were previously filed with the commissioner shall be filed as amendments in accordance with the provisions of Section 10290 and of Section 2202 of Title 10 of the California Code of Regulations.

(g) (1) Each health insurer shall report to the Managed Risk Medical Insurance Board the amount it has expended for health care services for individuals covered under a standard benefit plan under this section and the total amount of insured payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) September 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to August 30, 2007, inclusive.

(2) "Health care services" means the aggregate health care expenses paid by the health insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health insurer. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate such expenses for participating health insurers in the program. The "standard monthly administrative fee" is the average monthly, per person administrative fee paid by the program to participating health insurers during the reporting period.

(3) The "total amount of insured payments" is the aggregate of the monthly insured payments charged by the health insurer during the reporting period. The calculation of the total amount

of insured payments charged shall be consistent with the methodology used on July 1, 2002, to calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of insured payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health insurer and the insured payments received by the insurer. The verification shall include assurance that the insured was covered in the standard benefit plan during the reporting period in which the health insurer paid health care expenses on the insured's behalf, and that the expenses reported are consistent with the standard benefit plan.

(h) (1) The program shall pay each health insurer an amount that is equal to one-half of the difference between the total aggregate amount the health insurer expended for health care services for individuals covered under a standard benefit plan who have had 36 months of continuous coverage under the program and the total aggregate amount of insured payments charged to those individuals who have had continuous coverage under the program for a period of 36 consecutive months. For purposes of determining the amount the program shall pay each health insurer, the total aggregate amount the health insurer expended and the total aggregate amount of individual payments shall not include amounts paid by or on behalf of an individual who is eligible for Medicare Part A and Medicare Part B and who is not on Medicare solely because of end-stage renal disease. The program shall make this payment from the Major Risk Medical Insurance Fund or from any funds appropriated in the annual Budget Act or by another statute to the program for the purposes of this section. The state shall not be liable for any amount in excess of the Major Risk Medical Insurance Fund or other funds that were appropriated for the purposes of this section. If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health insurer, the health insurer may increase the monthly payments that its insureds are required to pay for any standard benefit plan to the amount that the Managed Risk Medical Insurance Board would charge without a state subsidy for the same plan issued to the same individual within the program.

(2) The Managed Risk Medical Insurance Board shall make a biannual interim payment to each health insurer providing coverage pursuant to this section. For the first two reporting periods described in this section, biannual interim payments shall be calculated for each insured as the product of the average premium in the program for that period of time the individual was covered during the reporting period and one-half of the difference between the program's prior calendar year loss ratio and 110 percent. For subsequent reporting periods, the Managed Risk Medical Insurance Board may, by regulation, adopt for each health insurer a specific method for calculating biannual interim payments based on the insurer's actual experience in providing the benefits described in this section. Each health insurer shall submit a six-month interim report of monthly insured enrollment in its standard benefit plan. The Managed Risk Medical Insurance Board shall make an interim payment to each health insurer pursuant to this section no later than 45 days after receipt of the insurer's coverage reports. Final payment by the board or refund from the insurer shall be made upon the completion of verification activities conducted pursuant to this section.

(i) The provisions of this section constitute a pilot program that shall terminate on September 1, 2007.

(j) This section shall become operative on September 1, 2003, and shall become inoperative on September 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the date on which the section becomes inoperative and is repealed.

SEC. 5. Section 10900 of the Insurance Code is amended to read:

10900. As used in this chapter:

(a) "Benefit plan design" means a specific health coverage policy issued by a carrier to individuals, to trustees of associations that cover individuals. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health services that has significant incentives for the covered individuals to use the system.

(b) "Carrier" means any disability insurance company or any other entity that writes, issues, or administers health benefit plans, as defined in subdivision (a) of Section 10198.6, that cover individuals, regardless of the situs of the contract or master policyholder.

(c) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(*l*) of the Public Health Service Act, as amended by Public Law 104-191.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504(e)).

(d) "Dependent" means the spouse or child of an eligible individual or other individual applying for coverage, subject to applicable terms of the health benefit plan covering the eligible person.

(e) "Federally eligible defined individual" means an individual who as of the date on which the individual seeks coverage under this part, (1) has 18 or more months of creditable coverage, and whose most recent prior creditable coverage was *coverage issued pursuant to Section 10901.2 or pursuant to Section 1399.804 of the Health and Safety Code, or coverage* under a group health plan, a federal governmental plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), (2) is not eligible for coverage under an employer-sponsored health benefit plan, Medicare, or Medi-Cal, and has no other health insurance coverage, (3) was not terminated from his or her most recent creditable coverage due to nonpayment of premiums or fraud, and (4) if offered continuation coverage under COBRA or Cal-COBRA, had elected and exhausted such coverage.

(f) "In force business" means an existing health benefit plan issued by a carrier to a federally eligible defined individual.

(g) "New business" means a health benefit plan issued to an eligible individual that is not the carrier's in force business.

(h) "Preexisting condition provision" means a policy provision that excludes coverage for charges and expenses incurred during a specified period following the eligible individual's effective date, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

SEC. 6. Section 10901.5 is added to the Insurance Code, to read:

10901.5. (a) This section shall apply to coverage for individuals who have maintained continuous coverage in the individual market for at least two consecutive years and who apply for coverage within 63 days of any termination of coverage when that termination is not based on fraud or nonpayment of premiums. Upon the effective date of this article, a health insurer shall fairly and affirmatively offer, market, and sell all of the insurer's policies that are sold to individuals in each service

area in which the insurer provides benefits and shall make available to each individual all individual policies that the plan offers and sells to individuals in this state.

(b) The insurer may not reject an application from an individual for an individual policy if the individual agrees to make the required premium payments and the individuals and their dependents who are to be covered by the policy work or reside in the service area in which the policy provides benefits.

(c) No policy or contract that covers an individual may establish rules for eligibility, including continued eligibility, of any individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors:

(1) Health status.

(2) Medical condition, including physical and mental illnesses.

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability, including conditions arising out of acts of domestic violence.

(8) Disability.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~SECTION 1. Article 3.12 (commencing with Section 1357.40) is added to Chapter 2.2 of Division 2 of the Health and Safety Code, to read:~~

~~Article 3.12. Individual Health Coverage Market Reform~~

~~1357.40. As used in this article, the following terms have the following meanings:~~

~~(a) "Dependent" means the spouse or child of an eligible individual, subject to applicable terms of the health care plan contract covering the individual.~~

~~(b) "Eligible individual" means a person who purchases an individual health care service plan contract who has met any statutorily authorized applicable waiting period requirements.~~

~~(c) "In-force business" means an existing health benefit plan contract issued by the plan to an individual.~~

~~(d) "Late enrollee" means an eligible individual or dependent who has declined enrollment in a health benefit plan at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan. However, an eligible individual or dependent shall not be considered a late enrollee if any of the following is applicable:~~

~~(1) The individual meets all of the following requirements:~~

~~(A) He or she was covered under another individual or employer health benefit plan or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.~~

~~(B) He or she certified at the time of the initial enrollment that coverage under another individual or employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.~~

~~(C) He or she has lost or will lose coverage under an employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an individual or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, or loss of no share-of-cost Medi-Cal coverage.~~

~~(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under an employer health benefit plan.~~

~~(2) A court has ordered that coverage be provided for a spouse or minor child under a covered individual's health benefit plan.~~

~~(3) The individual is a dependent of an enrolled eligible individual who has lost or will lose his or her no share-of-cost Medi-Cal coverage and requests enrollment within 30 days after notification of this loss of coverage.~~

~~(e) "New business" means a health care service plan contract issued to an individual that is not the plan's in force business.~~

~~(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the individual's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.~~

~~(g) "Creditable coverage" means:~~

~~(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.~~

~~(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.~~

~~(3) The Medicaid program pursuant to Title XIX of the Social Security Act.~~

~~(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.~~

~~(5) (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 10 U.S.C. Sec. 1071 and following).~~

~~(6) A medical care program of the Indian Health Service or of a tribal organization.~~

~~(7) A state health benefits risk pool.~~

~~(8) A health plan offered under (Federal Individuals Health Benefits Program (FEHBP) 10 U.S.C. Sec. 8901 and following).~~

~~(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.~~

~~(10) A health benefit plan under Section 5(c) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).~~

~~(11) Any other creditable coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).~~

~~(h) "Rating period" means the period for which premium rates established by a plan are in effect and shall be no less than six months.~~

~~(i) "Risk adjusted individual risk rate" means the rate determined for an eligible individual in a particular risk category after applying the risk adjustment factor.~~

~~(j) "Risk adjustment factor" means the percentage adjustment to be applied equally to each standard individual risk rate based upon any expected deviations from standard cost of services. This factor may not be more than 115 percent or less than 85 percent.~~

~~(k) "Risk category" means the following characteristics of an eligible individual: age, geographic region, and family composition of the individual, plus the health benefit plan selected by the individual.~~

~~(l) No more than the following age categories may be used in determining premium rates:~~

~~Under 30~~

~~30-39~~

~~40-49~~

~~50-54~~

~~55-59~~

~~60-64~~

~~65 and over.~~

~~However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under~~

~~the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the Social Security Act.~~

~~(2) Health care service plans shall base rates to individuals using no more than the following family size categories:~~

~~(A) Single.~~

~~(B) Married couple.~~

~~(C) One adult and child or children.~~

~~(D) Married couple and child or children.~~

~~(3) (A) In determining rates for individuals, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.~~

~~(B) (i) In determining rates for individuals, a plan that does not operate statewide shall use no more than the number of geographic regions in the state that is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service area divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.~~

~~(ii) If the formula in clause (i) results in a plan that operates in more than one county having only one geographic region, then the formula in clause (i) shall not apply and the plan may have two geographic regions, provided that no county is divided into~~

~~more than one region. Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.~~

~~(*l*) "Standard individual risk rate" means the rate applicable to an eligible individual in a particular risk category.~~

~~1357.401. Every health care service plan offering plan contracts to individuals shall, in addition to complying with the provisions of this chapter and the rules adopted thereunder, comply with the provisions of this article.~~

~~1357.402. This article shall not apply to health plan contracts for coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, Medi-Cal contracts with the State Department of Health Services, long-term care coverage, or specialized health plan contracts.~~

~~1357.4025. Nothing in this article shall be construed to preclude the application of this chapter to either of the following:~~

~~(a) An association, trust, or other organization acting as a "health care service plan," as defined under Section 1345.~~

~~(b) An association, trust, or other organization or person presenting information regarding a health care service plan to persons who may be interested in subscribing or enrolling in the plan.~~

~~1357.403. (a) Upon the effective date of this article, a plan shall fairly and affirmatively offer, market, and sell all of the plan's health care service plan contracts that are sold to individuals in each service area in which the plan provides or arranges for the provision of health care services. Each plan shall make available to each individual all individual health care service plan contracts which the plan offers and sells to individuals in this state.~~

~~(b) The plan may not reject an application from an individual for a health care service plan contract if the individual agrees to make the required premium payments and the individuals and their dependents who are to be covered by the plan contract work or reside in the service area in which the plan provides or otherwise arranges for the provision of health care services.~~

~~(c) No plan or solicitor shall, directly or indirectly, engage in the following activities:~~

~~(1) Encourage or direct individuals to refrain from filing an application for coverage with a plan because of the health status, claims experience, industry, occupation of the individual, or geographic location provided that it is within the plan's approved service area.~~

~~(2) Encourage or direct individuals to seek coverage from another plan because of the health status, claims experience, industry, occupation of the individual, or geographic location provided that it is within the plan's approved service area.~~

~~(d) No plan shall, directly or indirectly, enter into any contract, agreement, or arrangement with a solicitor that provides for or results in the compensation paid to a solicitor for the sale of a health care service plan contract to be varied because of the health status, claims experience, industry, occupation, or geographic location of the individual. This subdivision shall not apply with respect to a compensation arrangement that provides compensation to a solicitor on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the individual.~~

~~(e) No policy or contract that covers an individual may establish rules for eligibility, including continued eligibility, of any individual, or dependent of an individual, to enroll under the terms of the plan based on any of the following health status-related factors: (1) health status, (2) medical condition, including physical and mental illnesses, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability, including conditions arising out of acts of domestic violence, or (8) disability.~~

~~(f) Each plan shall comply with the requirements of Section 1374.3.~~

~~1357.405. Except in the case of a late enrollee, or for satisfaction of a preexisting condition clause in the case of initial coverage of an eligible individual, a plan may not exclude any eligible individual or dependent who would otherwise be entitled to health care services on the basis of an actual or expected health condition of that individual or dependent. No plan contract may limit or exclude coverage for a specific eligible individual or dependent by type of illness, treatment, medical condition, or~~

~~accident, except for preexisting conditions as permitted by Section 1357.406.~~

~~1357.406. (a) Preexisting condition provisions of a plan contract shall not exclude coverage for a period beyond six months following the individual's effective date of coverage and may only relate to conditions for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.~~

~~(b) A plan that does not utilize a preexisting condition provision may impose a waiting or affiliation period, not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period no premiums shall be charged to the enrollee or the subscriber.~~

~~(c) In determining whether a preexisting condition provision or a waiting or affiliation period applies to any person, a plan shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage with the succeeding plan contract within the applicable enrollment period. A plan shall also credit any time an eligible individual must wait before enrolling in the plan, including any affiliation or employer-imposed waiting or affiliation period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated, a plan shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan contract within the applicable enrollment period.~~

~~(d) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(e)).~~

~~(c) A health care service plan may not impose a preexisting condition exclusion to any of the following:~~

~~(1) To a newborn individual, who, as of the last day of the 30-day period beginning with the date of birth, has applied for coverage through the plan.~~

~~(2) To a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning with the date of adoption or placement for adoption, is covered under creditable coverage and applies for coverage through the plan. This provision shall not apply if, for 63 continuous days, the child is not covered under any creditable coverage.~~

~~(3) To a condition relating to benefits for pregnancy or maternity care.~~

~~1357.407. No plan contract may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No premium shall be charged to the late enrollee until the exclusion period has ended.~~

~~1357.408. All health care service plan contracts offered to an individual shall provide to subscribers and enrollees at least all of the basic health care services included in subdivision (b) of Section 1345, and in Section 1300.67 of the California Code of Regulations.~~

~~1357.409. No plan shall be required to offer a health care service plan contract or accept applications for such a contract pursuant to this article in the case of any of the following:~~

~~(a) To an individual, where the individual is not physically located in a plan's approved service areas, or where an eligible individual and dependents who are to be covered by the plan contract do not work or reside within a plan's approved service areas.~~

~~(b) To an individual, if the individual does not apply for coverage within 30 days following the individual's annual birth date. If a plan intends to limit enrollment of new individuals pursuant to this subdivision, which shall be known as the "birthday rule," the plan shall publicize its use of the rule on all marketing documents.~~

~~(c) Within a specific service area or portion of a service area where a plan reasonably anticipates and demonstrates to the satisfaction of the director that it will not have sufficient health~~

~~care delivery resources to assure that health care services will be available and accessible to the eligible individual and dependents of the individual because of its obligations to existing enrollees. Nothing in this article shall be construed to limit the director's authority to develop and implement a plan of rehabilitation for a health care service plan whose financial viability or organizational and administrative capacity have become impaired.~~

~~(d) Offer coverage to an individual or an eligible individual as defined under paragraph (2) of subdivision (b) of Section 1357.40 which, within 12 months of application for coverage, disenrolled from a plan contract offered by the plan.~~

~~(e) A health care service plan that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and 50 percent or more of the plan's total enrollment have premiums paid by the Medi-Cal program.~~

~~(f) A social health maintenance organization, as described in subdivision (a) of Section 2355 of the federal Deficit Reduction Act of 1984 (Public Law 97-369), that, as of December 31 of the prior year, had a total enrollment of fewer than 100,000 and has 50 percent or more of the organization's total enrollment premiums paid by the Medi-Cal program or Medicare programs, or by a combination of Medi-Cal and Medicare. In no event shall this exemption be based upon enrollment in Medicare supplement contracts, as described in Article 3.5 (commencing with Section 1358).~~

~~1357.410. The director may require a plan to discontinue the offering of contracts or acceptance of applications from any individual upon a determination by the director that the plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees. In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the plan's compliance with the requirements of Section 1367, Article 6 (commencing with Section 1375), and the rules adopted thereunder.~~

~~1357.411. All health care service plan contracts offered to an individual shall be renewable with respect to all eligible individuals or dependents at the option of the individual contractholder except:~~

~~(a) For nonpayment of the required premiums.~~

~~(b) For fraud or misrepresentation by the individual or his or her representatives.~~

~~(c) When the plan ceases to provide or arrange for the provision of health care services for new individual health care service plan contracts in this state; provided, however, that the following conditions are satisfied:~~

~~(1) Notice of the decision to cease new or existing individual health benefits plans in this state is provided to the director and to the contractholder at least 180 days prior to the discontinuation of the coverage.~~

~~(2) Individual health care service plan contracts subject to this chapter shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan which remains in force, any plan that ceases to offer for sale new individual health care service plan contracts shall continue to be governed by this article with respect to business conducted under this article.~~

~~(3) Except as authorized under subdivision (d) of Section 1357.409 and Section 1357.410, a plan that ceases to write new individual business in this state after the effective date of this article shall be prohibited from offering for sale new individual health care service plan contracts in this state for a period of five years from the date of notice to the director.~~

~~(d) When the plan withdraws a health care service plan contract from the individual market; provided, the plan notifies all affected contractholders and the director at least 90 days prior to the discontinuation of those contracts, and the plan makes available to the individual all plan contracts that it makes available to new individual business; and provided, that the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.412.~~

~~1357.412. Premiums for contracts offered or delivered by plans on or after the effective date of this article shall be subject to the following requirements:~~

~~(a) (1) The premium for new business shall be determined for an eligible individual in a particular risk category after applying a risk adjustment factor to the plan's standard individual risk rates. The risk adjusted individual risk rate may not be more than~~

~~115 percent or less than 85 percent of the plan's applicable standard individual risk rate.~~

~~(2) The premium charged an individual for new business shall be equal to the risk adjusted individual risk rate.~~

~~(3) The standard individual risk rates applied to an individual for new business shall be in effect for no less than six months.~~

~~(b) (1) The premium for in force business shall be determined for an eligible individual in a particular risk category after applying a risk adjustment factor to the plan's standard individual risk rates. The risk adjusted individual risk rates may not be more than 115 percent or less than 85 percent of the plan's applicable standard individual risk rate. The risk adjustment factor applied to an individual may not increase by more than 10 percentage points from the risk adjustment factor applied in the prior rating period. The risk adjustment factor for an individual may not be modified more frequently than every 12 months.~~

~~(2) The premium charged an individual for in force business shall be equal to the risk adjusted individual risk rate. The standard individual risk rates shall be in effect for no less than six months.~~

~~(3) For a contract that a plan has discontinued offering, the risk adjustment factor applied to the standard individual risk rates for the first rating period of the new contract that the individual elects to purchase shall be no greater than the risk adjustment factor applied in the prior rating period to the discontinued contract. However, the risk adjusted individual risk rate may not be more than 115 percent or less than 85 percent of the plan's applicable standard individual risk rate. The risk adjustment factor for an individual shall not be modified more frequently than every 12 months.~~

~~1357.413. Plans shall apply standard individual risk rates consistently with respect to all individuals~~

~~1357.414. In connection with the offering for sale of any plan contract to an individual, each plan shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:~~

~~(a) The extent to which premium rates for a specified individual are established or adjusted in part based upon the actual or expected variation in service costs or actual or expected variation in health condition of the individuals and dependents.~~

~~(b) The provisions concerning the plan's right to change premium rates and the factors other than provision of services experience that affect changes in premium rates.~~

~~(c) Provisions relating to the guaranteed issue and renewal of contracts.~~

~~(d) Provisions relating to the effect of any preexisting condition provision.~~

~~(e) Provisions relating to the individual's right to apply for any contract written, issued, or administered by the plan at the time of application for a new health care service plan contract, or at the time of renewal of a health care service plan contract.~~

~~(f) The availability, upon request, of a listing of all the plan's contracts and benefit plan designs offered to individuals, including the rates for each contract.~~

~~(g) At the time it offers a contract to an individual, each plan shall provide the small employer with a statement of all of its plan contracts offered to individuals, including the rates for each plan contract, in the service area in which the individuals and eligible dependents who are to be covered by the plan contract work or reside. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.~~

~~(h) Each plan shall do all of the following:~~

~~(1) Prepare a brochure that summarizes all of its plan contracts offered to individuals and to make this summary available to any individual and to solicitors upon request. The summary shall include for each contract information on benefits provided, a generic description of the manner in which services are provided, such as how access to providers is limited, benefit limitations, required copayments and deductibles, standard individual risk rates, an explanation of the manner in which creditable coverage is calculated if a preexisting condition or affiliation period is imposed, and a telephone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with whom the plan contracts to solicit enrollments or subscriptions.~~

~~(2) For each contract, prepare a more detailed evidence of coverage and make it available to individuals, solicitors, and~~

~~solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.~~

~~(3) Provide to individuals and solicitors, upon request, for any given individual, the standard individual risk rate. When requesting this information, individuals, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the individual's risk adjusted individual risk rate.~~

~~(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from individuals. For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.~~

~~(i) Every solicitor or solicitor firm contracting with one or more plans to solicit enrollments or subscriptions from small employers shall do all of the following:~~

~~(1) When providing information on contracts to an individual but making no specific recommendations on particular plan contracts:~~

~~(A) Advise the individual of the plan's obligation to sell to any individual any plan contract it offers to individuals and provide them, upon request, with the actual rates that would be charged to that individual for a given contract.~~

~~(B) Notify the individual that the solicitor or solicitor firm will procure rate and benefit information for the individual on any plan contract offered by a plan whose contract the solicitor sells.~~

~~(C) Notify the individual that upon request the solicitor or solicitor firm will provide the individual with the summary brochure required under paragraph (1) of subdivision (h) for any plan contract offered by a plan with whom the solicitor or solicitor firm has contracted with to solicit enrollments or subscriptions.~~

~~(2) When recommending a particular benefit plan design or designs, advise the individual that, upon request, the agent will provide the individual with the brochure required by paragraph (1) of subdivision (h) containing the benefit plan design or designs being recommended by the agent or broker.~~

~~(3) Prior to filing an application for an individual for a particular contract:~~

~~(A) For each of the plan contracts offered by the plan whose contract the solicitor or solicitor firm is offering, provide the individual with the benefit summary required in paragraph (1) of subdivision (h) and the standard individual risk rate for that individual.~~

~~(B) Notify the individual that, upon request, the solicitor or solicitor firm will provide the individual with an evidence of coverage brochure for each contract the plan offers.~~

~~(C) Notify the individual that actual rates may be 15 percent higher or lower than the standard rates, depending on how the plan assesses the risk of the individual.~~

~~(D) Notify the individual that, upon request, the solicitor or solicitor firm will submit information to the plan to ascertain the individual's risk adjusted individual risk rate for any contract the plan offers.~~

~~(E) Obtain a signed statement from the individual acknowledging that the individual has received the disclosures required by this section.~~

~~1357.415. (a) At least 20 business days prior to renewing or amending a plan contract subject to this article which will be in force on the operative date of this article, a plan shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357 and Section 1357.412. The certified statement shall set forth the standard individual risk rate for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be renewed or amended. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.~~

~~(b) At least 20 business days prior to offering a plan contract subject to this article, all plans shall file a notice of material modification with the director in accordance with the provisions of Section 1352. The notice of material modification shall include a statement certifying that the plan is in compliance with subdivision (j) of Section 1357.40 and Section 1357.412. The certified statement shall set forth the standard individual risk rate~~

~~for each risk category and the highest and lowest risk adjustment factors that will be used in setting the rates at which the contract will be offered. Plans that will be offering to an individual plan contracts approved by the director prior to the effective date of this article shall file a notice of material modification in accordance with this subdivision. Any action by the director, as permitted under Section 1352, to disapprove, suspend, or postpone the plan's use of a plan contract shall be in writing, specifying the reasons that the plan contract does not comply with the requirements of this chapter.~~

~~(c) Prior to making any changes in the risk categories, risk adjustment factors or standard individual risk rates filed with the director pursuant to subdivision (a) or (b), the plan shall file as an amendment a statement setting forth the changes and certifying that the plan is in compliance with subdivision (j) of Section 1357.40 and Section 1357.412. A plan may commence offering plan contracts utilizing the changed risk categories set forth in the certified statement on the 31st day from the date of the filing, or at an earlier time determined by the director, unless the director disapproves the amendment by written notice, stating the reasons therefor. If only the standard individual risk rate is being changed, and not the risk categories or risk adjustment factors, a plan may commence offering plan contracts utilizing the changed standard individual risk rate upon filing the certified statement unless the director disapproves the amendment by written notice.~~

~~(d) Periodic changes to the standard individual risk rate that a plan proposes to implement over the course of up to 12 consecutive months may be filed in conjunction with the certified statement filed under subdivision (a), (b), or (c).~~

~~(e) Each plan shall maintain at its principal place of business all of the information required to be filed with the director pursuant to this section.~~

~~(f) Each plan shall make available to the director, on request, the risk adjustment factor used in determining the rate for any particular small employer.~~

~~(g) Nothing in this section shall be construed to limit the director's authority to enforce the rating practices set forth in this article.~~

~~1357.417. The director may issue regulations that are necessary to carry out the purposes of this article. Prior to the public~~

~~comment period required on the regulations under the Administrative Procedure Act, the director shall provide the Insurance Commissioner with a copy of the proposed regulations. The Insurance Commissioner shall have 30 days to notify the director in writing of any comments on the regulations. The Insurance Commissioner's comments shall be included in the public notice issued on the regulations. Any rules and regulations adopted pursuant to this article may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Until December 31, 2006, the adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety or general welfare.~~

~~SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

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